CENTER FOR HEALING & HAPPINESS, PC
(734) 459-1760 Office
(734) 459-1797 Fax

NAME: _____
DATE OF BIRTH: _____

BEHAVIORAL HEALTH PROVIDER COMMUNICATION FORM

Patient Consent to Release/Exchange Medical Information (to be completed by patient or parent/guardian)

I, _____, _____, authorize / do not authorize the exchange of information
(Patient Name) (Date of Birth) (Circle One)

between the Center for Healing and Happiness, PC and: _____
Healthcare Provider Name

_____
Address City State Zip

_____
Telephone Number / Fax Number

To release/exchange information regarding my mental health/substance abuse treatment and including medical records for coordination of care purposes and as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care, HIV status, substance abuse care, diagnosis, treatment, psychotherapy notes, and/or treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my physician. The information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations.

Requested information: _____
_____
_____
_____
_____

_____ _____
Patient/Parent/Guardian Signature Date

To be filled out by Healthcare Provider only

Assessment/Admission Date: _____ Diagnosis:_____

Treatment Type: _____ Frequency:_____
(individual, family, group, medication) (weekly, bi-weekly, monthly)

_____ _____
Signature with Credentials Date